Local Enhancement and Development for Health (LEAD) Project: Second Annual Progress Report, October 2004 – September 2005

November 2005

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Second Annual Progress Report

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Second Annual Progress Report

Project:	Local Enhancement and Development (LEAD) for Health
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Local Enhancement and Development (LEAD) for Health Project

Second Annual Progress Report
(October 1, 2004 – September 30, 2005)

I. Executive Summary

LEAD for Health Project's second year was characterized by a substantial increase in the volume of technical assistance intended to strengthen the capacity of LGUs to finance, manage, and deliver family planning and other health services to their constituents. The year saw a sharp increase in enrolled LGUs that have collectively exhibited steady progress on the achievement of their performance targets. The different technical areas of the Project, as well as SIOs, and other regional and local partners, were mobilized to fulfill the technical assistance needs of enrolled LGUs.

The Project completed its strategy paper and started its implementation in all five provinces and lone city of ARMM. Significant strides have been made in securing national DOH support for the strategy. Efforts were made to enhance the capacity of DOH-ARMM and the regional government in managing multiple donor inputs, addressing the phase-down of donated contraceptives, and improving service provider capacity. An unprecedented number of heath facilities and district hospitals successfully obtained PHIC accreditation on OPB and MCP benefit packages through the application of an innovative fast-tracked strategy. Advocacy efforts have resulted in greater support for health by political leaders in the region.

The 10-point policy agenda was completed in Year 2, with the Project taking the lead in coordinating numerous consultations, discussions, and workshops with various national agencies and other USAID cooperating agencies. Guided by a unified policy development process, specific CAs and partner-institutions have started to pursue particular elements of the policy agenda.

The Project also completed the design for an advanced implementation of its performance-based grants. The advanced implementation allows 28 grants to two provinces and 23 municipalities in non-ARMM areas, and three provinces in ARMM. LEAD concluded preparatory activities with participating LGUs during the period, and expects to begin signing grants with LGUs early in the third year.

Accomplishments during the second year emphasize the integrative work that the Project has done, and continues to do. At the local level, this is clearly reflected in Project efforts at 1) integrating health and governance in its health governance strategy; 2) promoting an integrated approach – instead of a programmatic one – to local health service delivery; and 3) getting stakeholders from diverse backgrounds in a community to focus on and work towards a common set of health objectives. At the national level, the current multi-stakeholder collaboration on the 10-point policy agenda has mainly been the result of LEAD's initiative.

Year 2 provided a period of great learning for the Project. An assessment of its experience during the start-up and test phases has led to a shift in strategic approach that streamlined the Project intermediate results and focused technical assistance activities more tightly on the desired results. The Project was also led to look for more efficient and timely ways of providing technical assistance, and of maximizing existing technical resources especially offered by regional and local partners. Lessons and insights gained have informed the crafting of the Year 3 Work Plan, which is currently under revision to include inputs from the external assessment, the Year 2 Performance Report, and the September 2005 assessment report. The Year 3 Work Plan puts emphasis on sustaining and institutionalizing the lessons learned by the project in Year 2.

II. Project Overview

In 2003, the United States Agency for International Development (USAID) awarded the Management Sciences for Health (MSH) a cost-reimbursable three-year contract to implement the Local Enhancement and Development (LEAD) for Health Project.

LEAD aims to strengthen the governance and service capacities of local government units (LGUs) to provide quality family planning (FP), tuberculosis (TB), maternal and child health (MCH)/Vitamin A supplementation, and HIV/AIDS services. Its collaborating partners are the Department of Health (DOH), the Commission on Population (POPCOM), and the Philippine Health Insurance Corporation (PHIC, PhilHealth). The Project started implementation on October 1, 2003 and will complete its contract on September 30, 2006.

LEAD is USAID's largest project designed to fulfill Strategic Objective (SO) No. 3, "Desired family size and improved health sustainably achieved." SO 3 shall have been attained if the following intermediate results (IRs) are achieved:

1. LGU provision and management of FP, TB, MCH, and HIV/AIDS services strengthened
2. Provision of quality services by private and commercial providers expanded
3. Greater social acceptance of family planning achieved
4. Policy environment and financing of services improved

The LEAD Project seeks to specifically achieve IRs 1 and 4. Other USAID-funded projects contribute to the attainment of the other IRs.

A. Governance for Health Vision

LGUs are LEAD's primary clients. To strengthen their capacity to finance, manage, and deliver family planning and selected health services on a continuing basis, LEAD takes health governance as its springboard of assistance.

LEAD defines health governance as people and government collaborating to make health systems and services work. To see this through, LEAD provides technical and systems support to help LGUs plan, manage, and implement health programs more effectively. The Project ensures this in several ways. On the one hand, LEAD looks at LGUs' policy and budgeting processes. Results of this investigation inform the learning opportunities and tools the Project provides local chief executives (LCEs) to help them manage their health system. On the other hand, LEAD assists LGUs to take advantage of local non-government organizations (NGOs), technically identified as service implementation organizations (SIOs), through a system of technical assistance (TA) contracting.

The Project intervenes at different levels of the health system to strengthen not only the technical skills of health service providers. It also engages mayors and *Sangguniang Bayan* (SB, local legislative body) members to craft ordinances in support of FP and other health programs, budget officers to creatively source funding for health, the LGU leagues to hone their health advocacy and leadership skills, and the private sector to provide contraceptives to those who can afford to pay.

LEAD envisions that by the Project's completion, LGUs – with the support of local government institutions, and with the reinvigorated partnership among LCEs, LGU leagues, national health agencies, NGOs/SIOs, and the private sector – will have developed the capacity to continue implementing their health programs without external help.

B. Goals, Targets, and Geographic Coverage

At the end of its initial three-year contract, the LEAD for Health Project is expected to have generated outputs that contribute to the attainment of the following national targets:

1. Total fertility rate (2006) – 2.7
2. Contraceptive prevalence rate (modern, 2006) – 40%
3. TB treatment success rate (2006) – at least 70%
4. HIV seroprevalence rate among registered female sex workers – < 3% annually
5. Vitamin A supplementation coverage – 85% annually

To contribute to the achievement of these end-of-project goals, LEAD will enrol at least 530 municipalities and cities to participate in the Project. These LGUs come from 29 selected provinces in 14 of the country's 16 administrative regions. Together they have an estimated aggregate population of 31.57 million (based on 2000 census data). This constitutes 41.3% of the country's total population, and exceeds the 35% that the project contract requires.

With LEAD's technical, logistical, and other forms of assistance, these LGUs are expected to attain the following intermediate results:

1. Formulation of an LGU plan for strengthening governance and improving quality of FP, TB-DOTS, HIV/AIDS[1], and Vitamin A supplementation services

2. Implementation of a functional health information system

3. Formulation of a local contraceptive self-reliance plus (CSR+) plan[2]
4. Enactment of executive and legislative issuances that articulate support for the implementation of the local CSR+ plan

5. Provision of adequate funds for the implementation of the CSR+ plan

6. Enrolment of indigents in the National Health Insurance Program (NHIP)

7. a. Provision of universal Vitamin A supplementation
   b. Provision of Vitamin A supplementation to sick children

8. Attainment of *Sentrong Sigla* level 1 certification[3]

9. a. Attainment of PHIC accreditation for out-patient benefits (OPB) package
   b. Attainment of PHIC accreditation for TB-DOTS package
   c. Attainment of PHIC accreditation for maternity care package (MCP)

10. Reduction of high-risk behaviors among HIV/AIDS high-risk groups in HIV/AIDS sentinel sites

11. Reduction of family planning unmet need

C. Project Components and Major Technical Strategies

The LEAD for Health Project has two main components that correspond to the two intermediate results in USAID's strategic framework. Component 1 covers four tasks, and Component 2, three tasks.

<u>Component 1. Strengthening the local-level support for, and management and provision of FP, TB, and other selected services</u>

Task A. Increase local-level support for FP and other health services

Task B. Improve management and information systems for LGUs

Task C. Increase the availability of LGU financial resources for health services

Task D. Improve the quality of FP, TB, and other selected health services, and the performance of service providers

[1] In HIV/AIDS sentinel sites only
[2] The CSR+ plan covers FP, TB-DOTS, and Vitamin A supplementation services
[3] A DOH quality assurance initiative, literally translated to *center of vitality*

Component 2. Improve national-level policies to facilitate efficient delivery of quality FP and selected health services by LGUs

Task A. Improve national and local policies for increased financing of FP

Task B. Develop policies for mobilizing financing resources for services

Task C. Improve legal and regulatory policies for mobilizing financing resources for services

Component 2 is anchored on a 10-point Policy Agenda that the Project has developed together with other USAID cooperating agencies (CAs) and national partners. The 10-point Policy Agenda serves as the CAs' point of convergence in assisting national and local government partners pursue identified policy issues.

In addition to assisting USAID coordinate the work related to the 10-Point Policy Agenda, LEAD is primarily responsible for, and has begun to implement the policy initiatives listed below. These initiatives contribute to achieving the tasks under Component 2.

1. DOH certification and PhilHealth accreditation improved
2. PhilHealth benefit packages for FP, TB-DOTS, and maternity care expanded
3. PhilHealth operations to improve efficiency of PhilHealth–LGU transactions decentralized
4. National policies in support of CSR strengthened
5. Local policies strengthened in support of FP, TB-DOTS, Vitamin A, and HIV/AIDS through CSR+ planning, and executive and legislative agendas for health (ELAHs)
6. Financing of the National HIV/AIDS Surveillance System

Support to ARMM as a Special Strategy

The LEAD Project acknowledges the distinct and unique socio-cultural, political, religious, and geographic characteristics of the Autonomous Region in Muslim Mindanao (ARMM) as documented in LEAD's background studies. Corollary to this, the region requires a different implementing strategy from that which the Project is carrying out in non-ARMM areas. Hence, the Project is pursuing an implementation strategy that is tailored to ARMM's unique characteristics. Because of its non-devolved governance structure, a different set of LGU performance indicators has been developed for ARMM.

The LEAD strategy for ARMM focuses on the five output packages of the ARMM Health Improvement Strategy (ASHI). This strategy encompasses coordinated, high-impact interventions by LEAD partner-agencies in collaboration with other donors. The five packages are the DOH Output Package, the PhilHealth Output Package, the DOH-ARMM Output Package, the Community-based Output Package, and the Advocacy

Output Package. These packages seek to put in place technical and managerial systems that will contribute to the sustainable achievement of desired family size and improved health outcomes in ARMM.
The Project works closely with DOH, PhilHealth, and DOH-ARMM in pursuing the activities outlined in ASHI. Because ARMM's institutions are weak, project assistance will be provided through activities financed directly by LEAD or through NGO grants.

D. Tactical Approaches for Achieving and Sustaining LGU Performance Targets

To carry out the LGU capacity development activities outlined in Section I.C, the Project has adopted a number of strategic tactics that reflect what the Project has learned in terms of effectively working with LGUs to achieve and sustain the performance targets. This section describes some of those tactics.

1) Provincial approach to engaging LGUs

LEAD has adopted a provincial approach to engaging LGUs. This approach encourages the provincial government to express its interest to address population issues, and participate in the LEAD Project. The provincial government is requested to recruit eligible LGUs that are interested to join the Project.

Interested LGUs that LEAD has selected are convened in an orientation workshop where they are thoroughly briefed on the Project. They subsequently assess their existing capacities to deliver quality FP, TB-DOTS, HIV/AIDS, and MCH services in a sustained fashion. The outcome of this exercise is the LGU's work plan for achieving the 11 governance and service capacity development targets, together with the specification of the TA required to achieve them. The LGU then enters into an agreement with the LEAD Project. The agreement stipulates the technical and logistical assistance the Project will provide, and the governance and FP/health service capacity improvements the LGU commits itself to achieve.

The provincial approach also entails the establishment of provincial structures and systems necessary for LGUs to achieve the governance and service capacity IRs required to attain the LEAD end-of-project goals.

2) Provision of technical assistance

TA provision is the Project's main enabling tool for LGUs to achieve the governance and service capacity development performance targets. The Project taps service implementation organizations as its main provider of technical and managerial assistance to large numbers of LGUs.

The Project engages three types of SIOs: 1) provincial SIOs that service the TA needs of LEAD LGUs to achieve the targets, 2) HIV/AIDS SIOs for the TA needs of the 10 HIV/AIDS sentinel sites, and 3) central SIOs that provide specialized types of TA needed by any of the LEAD LGUs.

Other modes of providing TA to LGUs include direct contracting of short-term consultants, and engaging the staff of DOH central office, CHDs, provincial/city health offices, regional POPCOM offices, and regional PhilHealth units as trainers.

3) Use of the cohort planning approach

The Project has adopted the cohort approach to internally organize and plan TA activities for specific groups of LGUs. This approach was introduced after the Project recognized the need to organize the tremendous amount of technical assistance activities that have to be undertaken for and with the LEAD LGUs.

The cohort approach allows the Project to identify, prioritize, and pursue activities most critical to the achievement of specific intermediate results. It serves as a good indicative long-range planning tool for TA provision. It can also be used for more detailed planning over three to six-month periods. As such, it allows the Project to make confident estimates of the number of LGUs that will achieve particular IRs within specific time frames.

4) Forging strong ties with national collaborating institutions

LEAD's implementation progress can, to a large measure, be attributed to efforts to forge strong working relations with its major collaborators — DOH, PhilHealth, and POPCOM. It has enabled the Project to vigorously pursue the strengthening of technical capacities of CHDs, provincial health offices as well as PhilHealth and POPCOM regional offices so that they can continue providing TA to LGUs even after LEAD ceases to be. The strong collaborative partnership established among DOH, PhilHealth, POPCOM, and LEAD is the cornerstone of the Project's sustainability efforts.

5) Strategic alliance with the leagues of municipalities and provinces

Recognizing the potential long-term role of the LGU leagues in building political leadership for health, LEAD is working closely with the Philippine League of Provinces (LPP), and Municipalities (LMP). The leagues play a key role in advocating for LGU participation in the Project and sustaining their involvement. LEAD assists the leagues in governance capacity building activities; advocating stronger policy support for financing and provision of quality FP, TB, HIV/AIDS, and Vitamin A supplementation services; and mediating LGU-related conflicts that may arise in the course of project implementation.

6) Performance-based grant (PBG)

The provision of PBG is an innovative mechanism that encourages and rewards LGUs' good performance in health service delivery. It is another strategy the Project has adapted to supplement TA provision and support LEAD LGUs to achieve targets for local governance and service capacity development.

With the PBG mechanism, LEAD will disburse funds direct to LGUs upon their satisfactory achievement of agreed-upon benchmarks. Payment is linked to performance. This is expected to encourage the rapid achievement of pre-selected performance targets chosen from the 11 that LEAD LGUs are expected to achieve. The Project will start and complete the advanced implementation of the PBG program in the third year.

7) Utilizing the technical capacities of partner subcontractors

LEAD relies on its six major subcontractors to supply identified long-term staff and short-term technical assistance support. ARD, Inc. provides the Finance Specialist of the Policy Unit as well as Local Government Advisor, Management Development Specialist, and Advocacy Specialist of the Project's LGU Unit.

The Harvard School of Public Health provides short-term consultants and background literature searches to support the implementation of the policy agenda and the LEAD performance monitoring and evaluation plan.

JHPIEGO provides the FP Clinical Training Advisor and extends technical support to achieve the Project's family planning targets. Save the Children supplies the five Mindanao field coordinators. It also serves as SIO to service the TA needs of project LGUs in Iloilo, Maguindanao, and Sulu.

The Manoff Group, Inc. provides the Behavior Change Communication (BCC) Specialist as well as short-term TA to help the Project improve the behavior of FP, TB, MCH, and HIV/AIDS service providers.

The Center for Economic Policy Research (CEPR) served as a local partner on CSR and policy work until December 2004 when it reached the USAID limit of $250,000 in effect at that time.

E. Monitoring and Evaluation

LEAD has fully developed and begun implementing the plans, designs, and tools for monitoring and measuring project performance. The Project's Performance Monitoring and Evaluation Plan (PMEP) tracks performance at three levels: overall project performance, LGU performance, and the impact of LEAD on the strategic objective indicators.

PMEP has been recently updated to reflect the adoption of the cohort planning approach, the Project's new strategy for ensuring LGUs' achievement of intermediate results. The changes involve the reordering and simplification of the IRs, and correspondingly, the revision of IR indicators and the indicator tracking tool. The updated PMEP specifies the analyses that will be made on the quarterly LGU performance data, and the reports that will be prepared.

LEAD has formulated the indicators for each of the 11 governance and service capacity development performance targets (or intermediate results) that all Project LGUs will aim to achieve. These indicators are monitored quarterly. Monitoring results are used to track the LGUs' progress in achieving the performance targets, and determining the types of TA the LGUs further need to fully meet all targets.

Project performance is assessed through the quarterly benchmarks setting and review process which LEAD has been implementing since the first quarter of Year 1. The main audiences of the quarterly benchmarking meetings are the members of the Project Advisory Group and the Technical Advisory Group (recently replaced by an expanded Technical Interagency Technical Committee), and USAID staff.

LEAD has developed a Project Impact Evaluation Plan that will guide the measurement of the Project's impact on total fertility rate, contraceptive prevalence rate, TB case detection and cure rates, HIV/AIDS sero-prevalence, and Vitamin A supplementation coverage rates. The required baseline data have been collected from secondary sources and organized. The baseline report is currently being prepared.

A Performance Management Database System stores all LGU baseline and performance tracking data. The system is designed such that it not only organizes and reports quarterly performance data. It also produces key contractual documents (e.g., task orders for SIOs, grant agreements for LGUs). It thus serves as a tool for improving operational efficiency.

III. LEAD Performance in Year 2

A. Summary of Work in Year 2

Year 2 was characterized by a huge push to enrol new LGUs and assist them to accomplish as many performance targets as possible. During this period, the Project crafted and tested technical products (packages), refined them based on field experience, and used them in LEAD's work with LGUs.

The LEAD team and partners learned many lessons about how to work with LGUs, the the appropriate approach to use for a particular kind of province, and the importance of consistent follow-through. These lessons are being documented, disseminated, and applied in the field. Because of the sharp increase in the number of client-LGUs, the Project looked for more efficient and timely ways of providing technical assistance, and working with partners. LEAD also learned that not all LGUs move at the same pace and that approaches have to be tailored to meet their pace and needs.

The goals identified in the Year 2 Work Plan were pursued vigorously and tremendous progress was made in achieving each one. These are listed in Section III. B, with each goal elaborated on by a summary of accomplishments and an analysis of insights gained. These insights have informed the crafting of the Year 3 work plan, which is currently being revised to include inputs from the external assessment, the Year 2 performance

report, and the September 2005 assessment report. Some of the learning in the Project's second year pertain to the mechanisms LEAD uses to support and work with LGUs. Others were on packaging technical products and methodologies.

In Year 2 LEAD maintained its focus on LGUs as the primary client. At the same time, the Project's second year was marked by a concerted effort to reach out to partners and begin working with them on LGU support activities. While the first year of the Project involved much preparatory and organizational work, Year 2 was a period of accelerating the pace of activities with the LGUs as shown by the increasing number of LGUs accomplishing the many performance targets. It was also a period of significant progress on working with USAID, CA partners, and government counterparts on developing and implementing the 10-point Policy Agenda.

B. Analytical Review of Accomplishments

The implementation priorities that LEAD pursued in Year 2 were dictated by major outstanding issues that surfaced during Year 1 implementation. These were implementation priorities the Project needed to focus on Year 2 to come closer to achieving the end-of-project deliverables:

1. Enrol LGUs and provide TA in meeting performance targets
2. Maximize the deployment of the different technical areas in LEAD
3. Establish a system for large-scale TA provision to LGUs
4. Implement the LEAD strategy in ARMM
5. Complete the formulation of, and pursue the 10-point Policy Agenda
6. Establish the implementation feasibility of the LGU performance-based grants program

The following section of the report presents the Project's major accomplishments towards achieving each goal, and highlights major insights gained from undertaking these activities.

Goal #1. Enrol LGUs and provide TA in meeting performance targets

LGU Enrolment. As of September 30, 2005, LEAD has enroled 526 LGUs nationwide. Of the LGUs enroled, 425 are from non-ARMM areas and 101 are from ARMM areas.

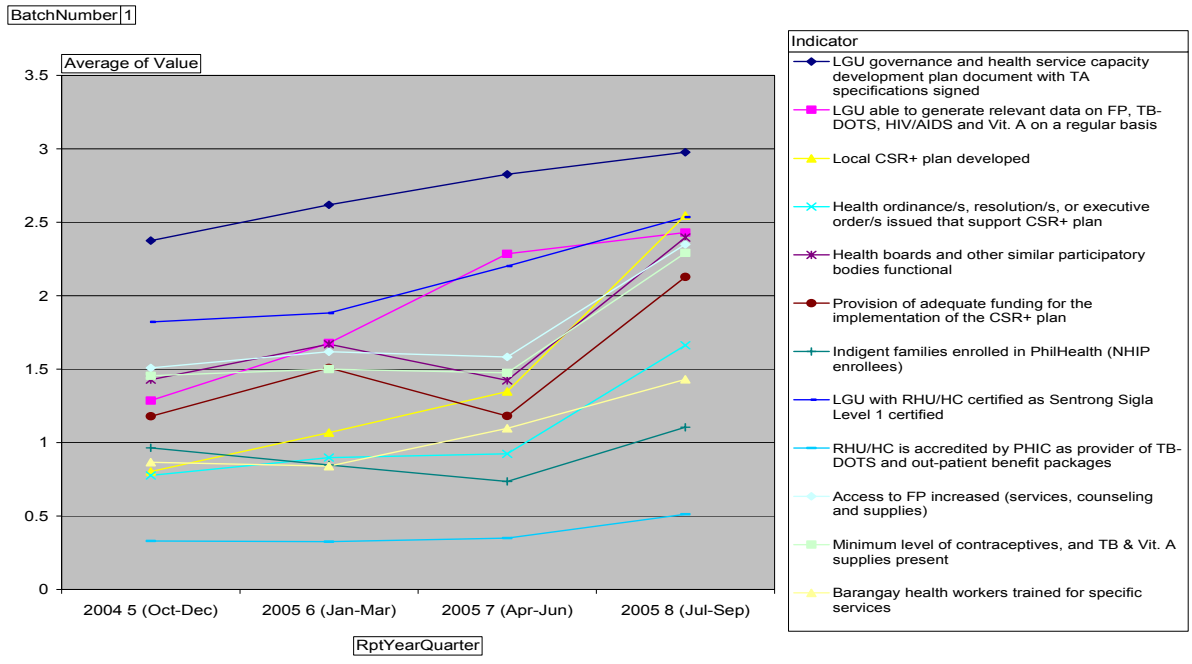
Of the 425 non-ARMM LGUs, 287 belong to the first two batches of LGUs and 138 belong to Batch 3, the last batch of LGUs to be enroled. The remaining 31 LGUs, belonging to the last group of LGUs from Pangasinan province, will be enroled early next quarter.

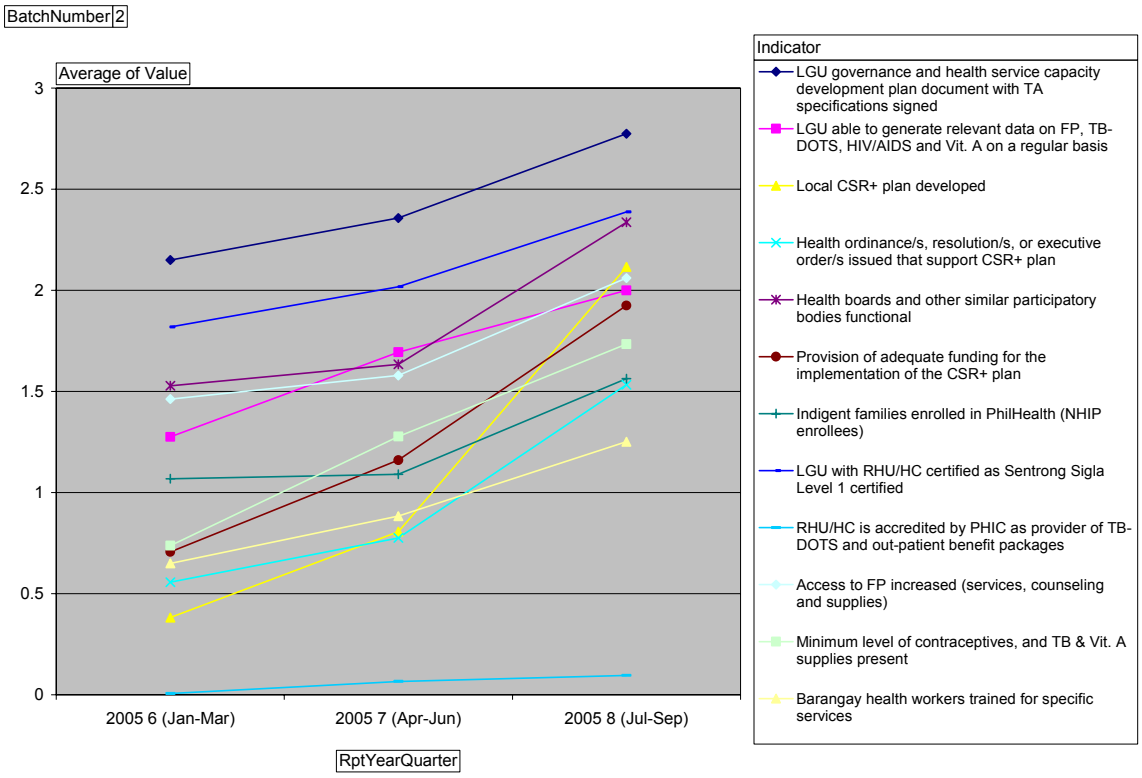
Except for 67 LGUs in Batch 3 that were only recently oriented on the LEAD Project, 87% of LEAD LGUs are currently receiving technical assistance from in-house staff, SIOs, and project partners to implement their LGU plans and accelerate achievement of performance targets.

LGU Performance. Enroled LGUs have been consistently making progress on the achievement of their targets. Figure 1 below shows the trend of Batch 1 and Batch 2 LGU performance in IR completion across the fifth till the eighth quarters. Average quarterly scores on the different indicators are clearly moving upward, indicating movement from lower to increasingly higher scores on the achievement of the different targets. (A score of three on a target means completion of that target.)

The two groups of LGUs show the same upward trend in meeting their performance targets. Moving from left (2004, Q5) to right (2005, Q8), the progress is generally on an upward trend, although Batch 2 LGUs exhibit a more accelerated pace in achieving their targets within less time (approximately two quarters from time of enrolment) compared to that of Batch 1 LGUs, which had been enrolled at least a quarter earlier. Both batches of LGUs have demonstrated marked progress in CSR plan development, access to FP services, budget allocation for CSR and in terms of functional health boards. Modest but consistent gains (increments in progress) are shown in the IRs on health information system, PhilHealth accreditation and indigent enrolment.

Figure 1: LGU Performance Trend By Batch from Q5-Q8





The accelerated performance of Batch 2 LGUs may be attributed to the LGUs' inherently good performance on governance and health system development. However, the following project- related milestones may also have contributed to the overall accelerated performance:

- *Development and refinement of technical products and interventions*. By the time Batch 2 LGUs were enrolled and started to receive TA, project technical products have been developed, tested, and piloted with the first batch. It took less time, then, to roll out these products among LGUs that were engaged later.

- *Engagement of more SIOs to assist more LGUs*. Compared to the number of SIOs enlisted to help the Project in TA provision to Batch 1 LGUs, there were more SIOs when the second batch came in.

- *Mobilization of more technical support from DOH, PhilHealth, and POPCOM*. In the second year, the Project increasingly tapped the assistance of its collaborating partners to provide TA to LGUs. CHDs, PHOs, and other regional and provincial partners, for instance, have been well represented in training of trainers in various technical areas. This has resulted in a greater number of available TA providers who can cover more LGUs.

Table 1 below shows the status of achievement of the different IRs[4] by the project LGUs as of September 30, 2005.

Table 1. Number of Non-ARMM LGUs Partially and Fully Meeting Intermediate Results and Percentage of LGUs Fully Meeting IRs, September 30, 2005 (N = 312)

Intermediate Result/Indicator	No. of LGUs Partially Meeting IR	No. of LGUs Fully Meeting IR
Intermediate Results		
LGU Plan	72	238
HIS	203	105
CSR+ plan	203	91
Executive Order/Ordinance	241	36
Health Board	180	125
Budget allocation for Health	257	42
NHIP enrolment	209	57
Sentrong Sigla certification	46	223
TB/OPB/MCH accreditation	24	26
Other Indicators		
Access to FP services	194	111
Reduced drop-outs	194	111
Existence of FP stock commodities	193	93
Training of volunteers and BHWs	278	22

Data on a critical intermediate result, FP unmet need reduction, is not included in the table. The Project is currently collecting CBMIS data from all engaged LGUs in order to come up with an accurate number of LGUs that have started to show reductions in FP unmet need. The revised Year 3 work plan will address the proposed strategies for rapidly reducing FP unmet need.

The performance targets which most LGUs have *fully met,* apart from development of LGU plans (76% of LGUs), are Sentrong Sigla certification (71%), local health boards (40%), FP services availability (36%), and health information system (34%). Targets where LEAD LGUs have shown progress in *partially* achieving are volunteer training, budget allocation, ordinance development, NHIP enrolment, CSR+ plan formulation, and health information system. The targets that exhibited significant increase from *minimal or none* in Q7 to *partial* achievement in Q8 are budget allocation, CSR+ plan formulation, and volunteer training.

PhilHealth accreditation of facilities for TB/DOTS, OPB, and MCP is one of the targets where LGUs demonstrated slower progress in achieving results. This is primarily due to

[4] Using old IRs. Q9 LGU tracking will reflect the monitoring of enhanced IRs and other qualitative information related to IRs

the effort and time required to prepare for and eventually obtain accreditation for each of the three benefit packages. For instance, the Project first needed to develop modules as well as train TA providers (DOH and other partners) and service providers to enable LGUs to conduct self-assessment and then apply for PhilHealth accreditation. Compared to other LGU performance targets then, the accreditation target needs more time to achieve. This is similar to the old IR on volunteer training, which is likewise considered one of the more difficult targets given the sheer number of volunteer workers in each LGU who need training.

There were a number of difficulties that had affected LGU achievement of specific performance targets. These are:

- Completing the enactment of health ordinances requires more time than other IRs because the passage of ordinances calls for multiple readings.

- The period when the Project enrolls an LGU greatly affects completion of the IR related to budget allocations. For most LGUs, unfortunately, engagement came at a time when budgets for the current year were already approved, preventing easy approval of further realignments and supplements for additional funding for health. This is particularly true for the 2005 budget allocations of LGUs. The Project expects more LGUs to make allocations for their health programs in the next budget cycle.

- Even with available funds, it has been difficult for LGUs to maintain stocks of critical commodities because of the absence of local suppliers. This is particularly true for Vitamin A and FP commodities.

- Local chief executives did not immediately warm up to the idea of enrolling indigents in the National Health Insurance Program. More intensive advocacy has to be done for them to appreciate the opportunity offered by NHIP indigent enrolment as a source of funds.

ARMM LGU Performance. ARMM LGUs' performance was previously measured using the LGU tracking form for regular or non-ARMM LGUs. However, the Project recognized that performance targets will be different for ARMM LGUs in light of the non-devolved set-up in, and other conditions unique to ARMM. Thus, the Project developed and pretested a provincial tracking form that is custom-fit for ARMM.

The major ARMM LGU activities that contributed to meeting overall project IRs are as follows:

- PHIC accreditation: A total of 79 health facilities in the five ARMM provinces and Marawi City were pre-assessed. Of these facilities, 27 were accredited for out-patient benefit package and seven were accredited for maternity care package. The rest of the facilities are still working on their accreditation requirements.

- Access to FP services, NHIP enrolment, financing, and local health boards and health ordinances:

    - Maguindanao mayors committed to enroll 28,000 indigents in NHIP (3,000 of these are enrolled to date)
    - In Sulu, Basilan, Tawi-Tawi, and Lanao del Sur 10 local health boards were organized and made functional
    - Basilan province formulated health ordinances
    - Lanao Sur initiated the user fee scheme to recover the cost of services and commodities
    - The Marawi City mayor, originally against family planning, committed to use PHIC capitation funds to procure FP commodities and added 6,000 more indigents for enrolment in NHIP
    - Access to health services in conflict-afflicted areas has been improved through the itinerant health team, an alternative service delivery model

***Insights gained*:**

2. The assessment and planning workshop provided the main venue for interested LGUs to assess their technical assistance needs and capacity to sustain the delivery of quality FP, TB-DOTS, MCH-Vitamin A supplementation services. The 11 governance and service capacity development targets served as reference point for the assessment. To get the interest of LGUs in meeting these targets, it was important to point out that these targets, which are also the Project's intermediate results, are the very same elements of a robust local health system. With or without LEAD, an LGU that wants to cultivate a vibrant and sustainable health system would be aiming for the same components.

3. In some cases, the period between enrolment and subsequent TA provision had been over-extended. Experience, however, has shown that focused follow-up on, and on-site support to specific LGUs after a workshop are critical. FCs and technical specialists have to ensure that TA the LGUs need to implement or practice what has been learned during the workshop is adequately provided on time. This implies that "generic" technical assistance packages, such as training of trainers and corresponding modules, are effective only up to a certain extent. Individual LGUs still need guidance in translating the learning from these trainings into specific activities and practices to achieve desired outcomes.

4. Specific follow-through technical assistance (e.g., mentoring and coaching) necessary after the conduct of trainings and workshops need not come only from the Project staff. It may be more efficient to have other TA providers work with the LGUs. CHDs, SIOs as well as LGUs that are more experienced in meeting the performance targets may be tapped to do the follow-through.

Goal #2. Maximize the deployment of the different technical areas in LEAD

The bulk of activities in the Project's technical areas is intended to enable LGUs to meet their performance targets, and accomplish the tasks under Component 1. This section highlights the accomplishments made under Component 1 as a result of these activities.

Component 1: Strengthen the local-level support for, and management and provision of FP, TB, and other selected services

LEAD technical areas have provided technical, logistical, and other forms of assistance that have led to the accomplishments under each task:

Task A: Increase local-level support for FP and other health services

Strategic engagement with the leagues of municipalities and provinces of the Philippines. The League of Municipalities of the Philippines and the League of Provinces of the Philippines are important LEAD partners in increasing local support for FP and other health services. In an LMP general assembly convened by the Project in December 2004, approximately 1,000 mayors passed Resolution No. 009-2004, "*Resolution Pushing for the Implementation of Reproductive Health Programs and Responsible Parenthood in All Municipalities with the Municipal Mayors Taking the Lead*." This resolution is a manifestation of LMP's support for the implementation of the DOH Contraceptive Self-Reliance (CSR) AO 158 in all LMP chapters.

The same resolution served as the springboard for an LMP nationwide campaign, "*Kung Maliit ang Pamilya, Kayang-kaya*" (KMP KK). The campaign, launched in February 2005, covered 13 provinces (Isabela, Nueva Ecija, Bulacan, Rizal, Capiz, Guimaras, Negros Occidental, Negros Oriental, Biliran, Davao del Norte, Bukidnon, Agusan del Sur, and South Cotabato) and reached 217 municipalities. Conceptualized and launched with financial and technical assistance from LEAD, the campaign sought to spur local chief executives to support the local implementation of the CSR strategy through policies that promote responsible parenthood and reproductive health, and by allocating funds for contraceptive purchase or for improvements in family planning service delivery. LEAD took the opportunity to talk in each campaign site about modern family planning methods and to correct myths about them. Training in no-scalpel vasectomy and behavior-focused client generation were also conducted in sites that had requested for this assistance.

Of note were the strong and effective coordination efforts among various sectors to make the campaign successful. Preparatory meetings were held with LMP local chapter presidents, municipal health offices (MHOs), and local LMP coordinators in all 13 sites. In these meetings, the Tiarht Amendment was also thoroughly discussed. Mayor Gerry Calderon, LMP Secretary General, and representatives from the National Secretariat, attended all KMP KK activities. In the Visayas, the Secretary General hopped from one radio station to another to explain what the KMP KK campaign is all about. The LMP President, Mayor Ramon Guico, also attended the national launch in Angono. He

verbalized his personal and LMP's support to the family planning initiative during the press conference, saying that the LMP was serious in its pursuit of FP at the local level.

A LEAD–LMP-initiated assessment of the campaign held in June 2005 revealed a surge in the number of local resolutions supporting CSR, responsible parenthood, and family planning programs after the round of KMP KK local launches. As of July 30, 2005, seven chapter resolutions and 39 municipal resolutions have been passed.
An analysis of the performance of LEAD LGUs in the provinces that participated in the campaign indicated that, on the average these LGUs had accelerated progress towards achieving their performance targets especially after the campaign.

The assessment identified a number of factors that were critical to the success of the KMP KK campaign:

1. The commitment of local chief executives and *Sangguniang Bayan* (local legislative body) members
2. LGUs' ownership and championing of the campaign as well as strong grassroots support
3. Setting aside political partisanship to work together towards the success of the campaign, with LMP as the prime mover in generating commitment from municipal mayors of differing political parties
4. Close coordination with other sectors, i.e., NGAs, NGOs, and LGUs themselves

Local advocacy. LEAD gained major headway in organizing local advocacy networks that champion the sustained financing and provision of quality FP, TB-DOTS, HIV/AIDS, and MCH services. These support groups influence local governance to initiate actions needed to achieve the LGU performance targets. The Project has organized four advocacy groups: The Mayor–Doctors for Health, an aggregation of local chief executives who are medical doctors; the Davao Health Advocacy Network in Davao City; the HANAS-Dabaw in Davao del Norte; and the Baguio City Advocacy Network for Health and Population (Baguio-CAN).

Strengthening local-level support/local multi-sectoral response to HIV/AIDS. LEAD works with the Philippine National AIDS Council to further strengthen implementation and local interpretation of national policies supportive of financing and delivery of HIV/AIDS prevention activities at the local level. Technical assistance to strengthen local-level support has been provided mainly by HIV/AIDS SIOs engaged in the first quarter of 2005 for seven sentinel sites (viz., the cities of Angeles, Quezon, Pasay, Iloilo, Davao, Gen. Santos, and Zamboanga).

Upon engagement, the SIOs set out to strengthen linkages with LGU officials, chief executives, identified policy champions, and other stakeholders such as entertainment establishment owners and managers. In some of the sites, formal agreements with the LGU in support of the Project were sealed off through the signing of a memorandum of agreement (MOA) which stipulates the objective, scope, and other details of the

undertaking. Some stakeholders creatively referred to the agreement as "Covenant of Partnership" or "Commitment of Support."

Local AIDS councils (LACs) were reconvened, and strategic plans were developed with them. This has resulted in an expanded base of local advocates for HIV/AIDS program and services, and has brought these stakeholders into the mainstream of local HIV/AIDS prevention and control program of the city. The LACs have worked on popularizing Republic Act 8504 or the Philippines AIDS Law, and local AIDS ordinances. Related laws, ordinances, and resolutions on HIV/AIDS prevention and control have been compiled and referenced in assessing the current policy environment, and developing new policies in support of HIV/AIDS programs and services.

Linkages and resource partnerships with government and non-government organizations (GOs, NGOs), and other sectors in the community were likewise expanded and strengthened for the prevention of STI and the rapid increase of HIV/AIDS. Other support groups (e.g., federation of entertainment establishment owners and managers, association of female sex workers) were reorganized and strengthened to mobilize support for the city's HIV/AIDS efforts. Peer educators were recruited and trained by SIOs to assist in project implementation on a voluntary basis in their respective sites.

Task B: Improve management and information systems for LGUs

Health information systems development. One of the key development objectives of the LEAD Project is to enhance health data use by health service managers and staff. Towards this end, the Project supports existing systems (e.g., community-based monitoring and information systems or CBMIS, Field Health Service Information System or FHSIS, and TB reporting systems) rather than develop new ones or add to the reporting burden that existing systems already put on health facilities. Technical assistance, therefore, has focused on enhancing LGUs' management and use of information to support family planning, Vitamin A supplementation, vaccination, and TB control services.

LEAD puts emphasis on improving CBMIS because this system allows the community to collect and manage data that it can immediately use for health program planning. With CBMIS, LGUs can gather data on the following:

- Family planning data from both the public and private sectors:
    - Unmet need for FP
    - Method mix
    - Source of supply or service (public and private sector)
    - Number of women of reproductive age

- Vitamin A supplementation
    - Children needing Vitamin A supplementation
    - Vitamin A coverage

- Tuberculosis (optional for LGUs opting to do active case finding)
    - TB symptomatics not seeking consultation
    - Diagnosed TB patients not taking any medication
    - Diagnosed TB patients with irregular intake of medications
    - TB patients with no TB-DOTS treatment partners

The Project has targeted to help at least 80% of *barangays* (villages) in engaged LGUs in implementing the CBMIS. CBMIS, however, has not been introduced in LGUs that have existing local information systems that can generate data on the above.

In its second year, LEAD trained a total of 229 cities and municipalities in 12 regions and 18 provinces in CBMIS implementation. The series of training sessions has produced 1,177 trainers among LGU staff, 63 trainers from PHOs, and 49 trainers from CHDs. In addition to these, 20,553 barangay health workers (BHWs) have been trained in collecting CBMIS data. LEAD introduced a data validation tool to help MHOs, program managers, and management information system (MIS) personnel to periodically check the accuracy of transcribing information related to health services from the data gathered through the system.

To enable LGUs to use CBMIS data, LEAD trained regional and provincial staff in teaching LGUs skills in data processing, analysis, and utilization. This was done in coordination with the DOH National Epidemiology Center (NEC), and using a group instructional module, "Enhancing Information Use for Managing Health Services," developed by NEC and LEAD. Twelve regional staff from four regions, and 13 provincial staff from five provinces in Mindanao have been trained. The training schedule for Luzon and Visayas trainers will be set when NEC approves the module's nationwide dissemination.

To date, 229 LGUs are already implementing their CBMIS; the others are in different stages of implementing the system.

As indicated above, LEAD also provides technical assistance to LGUs that are currently developing or improving their locally initiated information systems. Technical assistance has ranged from data validation and analysis to actual use of data in planning for service provision. The LGUs that are in this group are the following:

- 17 LEAD LGUs in Pangasinan under their community-based family planning monitoring system. The system utilizes one barangay service point officer (BSPO) per barangay in gathering FP data
- 17 LEAD LGUs in Capiz using the "*Bisita sa Pamilya* (family visit) Survey" to get population data on health
- 16 NCR LGUs that are finalizing their own system of gathering population-based data. The system is called community-based monitoring and information system reaching every depressed area, or CBMIS-RED

Strengthening the HIV/AIDS information systems in sentinel sites. The HIV serologic surveillance (HSS) and behavioral surveillance system (BSS) are important tools in predicting the trend of infection and the nature of risky behavior among most-at-risk-groups. Together with the sentinel STI etiologic surveillance system (SSESS), they provide valuable information that can help both national and LGU institutions monitor the HIV/AIDS epidemic and guide their responses. The information also enables LGUs to initiate or design focused behavioral change interventions for vulnerable groups and allocate resources to HIV/AIDS work.

LEAD has engaged a central SIO, Family Health International (FHI), to provide technical assistance to DOH-NEC and participating sentinel LGUs in strengthening the current HIV/AIDS/STI information system and make it more responsive to the current HIV/AIDS-related information needs of the country. Likewise, to ensure that the components of the existing national surveillance system are in line with current global best practices, and that it is able to provide an accurate picture of the HIV infection prevalence in sentinel sites and the country as a whole.

All these efforts to strengthen the current surveillance system resulted in the development of the Integrated HIV Behavioral and Serologic Surveillance (IHBSS) system, the design of which was completed in January 2005, replaces the old Philippine HIV surveillance system. A training manual for the IHBSS team preparation was developed and used in preparing surveillance implementers and partners for the first IHBSS surveillance round.

The first data collection activity for the 2005 IHBSS took place in April until June 2005. Behavioral and serologic data were collected in all sentinel sites using the revised protocol. The initial data analysis phase started in mid-July during the first workshop on data analysis using the STATA software, a statistical software that, until then, had never been used to analyze surveillance data in the Philippines. All 10 sentinel sites generated statistical data for analysis using the software.

The first surveillance round was later reviewed, and recommendations for addressing difficulties faced during the implementation were proposed. The IHBSS Manual of Procedures (MOP) was also developed to guide the 10 sentinel sites in the implementation of subsequent IHBSS rounds, as well as other sites that would decide to implement HIV surveillance in the future. Quality assurance mechanisms still need to be developed and incorporated into the IHBSS MOP to ensure the reliability of HIV surveillance findings in all sites and in every round.

Size estimation of the population with high-risk behaviors is part of the second generation surveillance system. In line with the overall support to the DOH to strengthen surveillance, the Project also embarked on the Training on Size Estimation Methods for Populations at High Risk for HIV in September. Based on available data in sentinel sites, the training yielded good size estimates of the sub-populations at risk for HIV. These estimates will provide better understanding of the burden of the disease which, in turn, will result in better-informed programs and policies in these sites.

Task C: Increase the availability of LGU financial resources for health services

The LEAD Project provides technical assistance to LGUs to help them increase financing for health services. Technical assistance in this area comes in various forms: workshops and coaching on CSR+ plan formulation and implementation, health budgeting and financing, formulation of executive legislative agenda for health, and formulation of health-related tax ordinances.

CSR+ plan formulation and implementation. The CSR+ workshop in LEAD LGUs is intended to assist them in the preparation of their respective plan that will implement their CSR strategy in accordance with DOH Administrative Order No. 158 issued July 9, 2004. LGUs prepared forecasts of their FP commodity requirements in response to the phase-out of donated contraceptive supply as well as their commodity requirements for TB and Vitamin A supplementation. Then, they assessed and decided on strategies to mobilize resources to finance their commodity requirements for the four core programs.

A draft manual for the CSR+ is being finalized. The manual was pretested in the training of trainers for the CSR+ workshop conducted in Caraga and Region 10.

As of September 30, 2005, CSR+ workshops have been conducted in 194 municipalities and cities in 20 provinces. As a result of these planning workshops, total funds amounting to PhP67,659,849 (PhP27,590,427in Luzon, PhP26,612,810 in Visayas, and PhP13,456,612 in Mindanao) were allocated for family planning for FY 2005-06.

LEAD consultants and the JSI Logistics Management Team had undertaken 39 logistics policy formulation workshops (19 provinces and 20 cities), 18 policy formulation follow-up workshops (13 provinces and 5 cities), 1 training of trainers and 1 roll-out training on the modified contraceptive delivery and logistics management information system (CDLMIS) forms for Pangasinan Province. Thus far, only one province, i.e., Pangasinan, has completed all the trainings planned by the Policy Unit.

Health budgeting and financing. The health budgeting and financing workshop is a follow-up activity to the CSR+. It aims to assist LEAD LGUs in formulating action plans to increase the budget of the city/municipal health office for priority health programs and projects like family planning, MCH, TB and HIV/AIDS, etc.; identify various sources of financing for health programs and projects, particularly on family planning, MCH, TB and HIV/AIDS, etc.; and formulate health-related tax ordinances to implement the identified financing strategies.

In this workshop, LGUs review the financing requirements indicated in their local governance and health service capacity development plan and the CSR+ plan. Specifically, the participants, particularly the municipal/city health officers, are oriented on how and where to place in the annual budget funding for 1) commodity requirements for FP, TB, HIV/AIDS and Vitamin A supplementation, 2) upgrading rural health units/health centers (RHUs/HCs) and other health facilities; 3) enrolment of indigents in NHIP, and 4) other health activities related to the four core programs.

LGUs also prepare an action plan for their financing strategies, and formulate health-related tax ordinances. The latter is particularly useful to LGUs that opt to impose new or increase health-related fees, or revise their revenue code. To ensure funding for FP, TB, and Vitamin A supplementation, LGUs included in the ordinance a provision creating a special account called "health fund" in the general fund where the proceeds of health-related fees or other impositions will accrue to fund health programs.

A draft manual for facilitators on the conduct of this workshop is being revised to include the latest change involving activities on the last day – incorporation of the health-related tax ordinance formulation.

Formulation of an executive-legislative agenda for health.. The ELAH activity aims to discuss and plan how to incorporate population and health concerns in the executive-legislative agenda of LGUs; determine the legislative requirements for the health program on family planning, tuberculosis, HIV/AIDS and Vitamin A supplementation; and prepare an action plan to implement the identified legislative requirements. Programs, projects, and activities in the ELAH plan are given priority in the annual budget of LGUs. In instances where the LGUs have already prepared their ELA, they made an enhancement on the health sector specifically incorporating FP, TB, HIV/AIDS, and Vitamin A supplementation.

Improving national and LGU financing for HIV/AIDS. LGUs' commitment to sustain the comprehensive HIV/AIDS program in their respective areas is mirrored, ultimately, in the allocation of resources for the program. HIV/AIDS SIOs as well as the provincial SIOs have been assisting LACs to mobilize more funds for their respective HIV/AIDS programs. The sentinel sites have formulated action plans for mobilizing local budgetary resources sufficient to finance a level and scope of HIV/AIDS surveillance as well as prevention and control activities responsive to infection risks at the local level.

At the national level, LEAD provided technical assistance to DOH-NEC to develop the latter's capacity in identifying and securing financing from various sources, and advocate for the approval of the long-term financing plan for this system. This has led to the formulation of a three-year financial plan for the surveillance activity. It has also reinforced prior implementation arrangements with LGUs on shouldering specific budgetary line items for surveillance.

Task D: Improve the quality of FP, TB, and other selected health services and the performance of service providers

In the second year, LEAD completed and obtained approval of its technical strategies, particularly for TB-DOTS, HIV/AIDS, and MCH. With the completion of these strategies, the Project made good progress in developing and providing technical assistance packages to help LGUs achieve their performance targets, particularly those relating to improvements in health service provision.

Family Planning:

The second year witnessed significant progress in the implementation of the family planning strategy. Major accomplishments were in the training of BHWs in family planning client motivation and services support, and of RHU and HC service providers to ensure that a broad mix of contraceptive methods is available at service points. Significant strides were also made in the organization of training networks in procedural methods of no-scalpel vasectomy (NSV), minilaparotomy under local anesthesia (MLLA), and IUD insertion. Such networks were organized in CHDs 11, 6, and NCR, and in the provinces of Davao del Norte, Capiz, and Iloilo.

Training networks were established in two ways. LEAD organized a network of trainers for VSS and IUD at the central level while it also assisted CHDs/PHOs establish networks of trainers. These two structured networks complement and supplement each other. Such networks were organized in CHDs 5, 6, 7, 11, 12, CAR, NCR, and ARMM; and in the provinces of Albay, Sorsogon, Catanduanes, Capiz, Iloilo, Negros Oriental, Davao del Norte, South Cotabato, and Benguet. The established networks in Region 11and 6 are functional. Through these networks, service providers in Davao del Norte, Compostela Valley, Iloilo, Capiz, and Sorsogon were trained on NSV and MLLA. An IUD network was established in Region 6 for the provinces of Capiz and Iloilo, and in Region 5 for Sorsogon province. To support FP training, LEAD developed a whole package of training modules/materials that includes training kits for NSV, MLLA, and IUD.

The Project is also actively developing capacities of RHUs and health centers of LEAD LGUs to conduct family planning action session (FPAS), a group-counseling method that does not replace the individual counseling. Save the Children modified the FPAS used in the first batch of training of trainers participated in by Capiz, Iloilo, Davao del Norte, and Sorsogon. The final version of the FPAS training module was utilized in the training of 35 public health nurses in Davao del Norte and health personnel in ANIHEAD-Iloilo municipalities. Family planning community-based training was also conducted among untrained RHU personnel and barangay health workers in LEAD-assisted areas.

LEAD conducted several meetings/conferences to strengthen the technical support the Project is providing. The pool of core trainers on VSS (NSV and MLLA) and IUD insertion was convened in several consultative meetings to increase the trainers' awareness of and commitment to applying the training approach. In September 2005, the Project conducted a national consultative forum for VSS service providers and trainers to present and discuss project outputs and best practices of different regions across the country.

LEAD's major key tasks in family planning – CBMIS, VSS/IUD training, governance, and advocacy – converged in the BCC-FP component, weaving together seemingly disparate activities to collectively result in the reduction of FP unmet need. This BCC integrated approach was necessary to ensure a multifaceted track to behavior change among providers and to improve client-provider relationship. Ultimately, this behavior change will move clients towards adopting behaviors that will lead to family planning.

The approach served to contextualize BCC technical assistance vis-à-vis other technical areas and provide a packaged continuum of assistance to LGUs. It provided a basis for joint planning and implementation with other technical areas in the Family Planning and Health Systems Unit and the LGU/Field Operations Unit.

A behavior change communication package was developed, implemented, and integrated into the KMP KK launching activities in Biliran and Bukidnon provinces. Service providers in these provinces were trained on practical market research, behavior trials, client response and satisfaction, and communication planning. The provision of BCC-FP technical assistance in aid of KMP KK tested the viability and effectiveness of the integrated BCC package. It also harnessed the enthusiasm, leadership, and initiative of local chief executives in reducing FP unmet need beyond mere ceremonial launches. More importantly, embedded in the integrated approach was the discussion and concretization of the principles of informed choice and voluntary decision-making (Tiarht Amendment).

Although the BCC-FP package conducted for the KMP KK sites was for the campaign, the package is also useful for routine health service provision not only in family planning but in other technical areas as well. The BCC-FP approach and package offered a different perspective and more solid activities to reduce unmet need, departing from the usual "IEC mentality" of LGUs and other groups. Tools were also developed to provide baseline data to measure the communication training needs of LGUs, inventory IEC materials, and gauge the communications skills level of health education and promotion officers (HEPOs). All of these served as bases for strategic technical assistance scheduling and intervention, and sustainability plans.

TB-DOTS:

Significant progress was also achieved in carrying out the LEAD strategy for tuberculosis prevention and control, the primary aims of which are to assist project LGUs obtain DOH certification and PhilHealth accreditation as TB-DOTS package service providers, attain commodity security for TB drugs, and strengthen policy support for TB services provision.

The Project assisted in developing the guidelines on providing technical assistance to rural and city health centers to enable them to meet the requirements for DOH certification, and PHIC accreditation of their TB-DOTS outpatient benefit package.

LEAD developed a training module on TA provision that was used to train 92 trainers from the 17 CHDs and SIOs. A team of provincial TA providers, composed of provincial TB coordinators and DOH representatives, had been trained in 11 LEAD-engaged provinces. TA was also provided during the self-assessment activities on TB-DOTS certification in some provinces. Assistance had been provided in establishing provincial TB diagnostic centers and public-initiated public-private mix DOTS (PPMD).

LEAD conducted various types of training activities to improve the quality of TB-DOTS services in project LGUs, including those in ARMM. Microscopists from NCR and five provinces underwent a five-day training course on basic microscopy to improve access and quality to this diagnostic tool.

In light of a national survey finding that almost 20% of TB patients consulted a hospital, LEAD helped DOH develop guidelines on establishing an effective referral system between public hospitals (regional, provincial, and district) and health centers. This is called public-public mix DOTS (P2PMD).

The Project developed a tool for forecasting the financial requirements for the purchase, as LGU counterpart, of anti-TB drugs. The Project assisted DOH-ARMM in the design of the provincial TB program implementation review (PIR), and improving the monitoring and evaluation skills of provincial and district TB program coordinators.

MCH-Vitamin A:

Significant accomplishments were likewise chalked up in pursuing the LEAD MCH strategy. The Project assisted in developing a tool for LGUs to forecast Vitamin A requirements for high-risk and sick children. It developed as well a guide for Vitamin A supplementation to high-risk and sick children and a chart on Vitamin A supplementation for all target groups.

In addition, a protocol for assessing Vitamin A supplementation coverage and rapid coverage assessment was developed and introduced during the DOH zonal workshops with participating provincial and city health offices. It developed training manuals for TA and service providers for the maternity care benefit package and out-patient benefit package. There are now technical assistance providers for MCP/OPB in all CHDs (except CHDs 2 and 4), provincial health offices (except Bukidnon), and PHIC per region. The TA providers of Negros Oriental, Eastern Samar, Negros Occidental, and South Cotabato trained service providers and other LGU stakeholders on MCP/OPB accreditation and reimbursement. Bindoy RHU of Oriental Negros is now MCP accredited.

LEAD assisted DOH-ARMM in developing a guide for strengthening the partnership of midwives and traditional birth attendants for improved maternity and newborn care services. All five provinces of ARMM, Marawi City, and DOH-ARMM have trainers on strengthening midwife-*hilot* partnership. Maguindanao provincial health trainers trained 25 midwives on the use of this guide.

LEAD has enhanced and expanded the parent/caregiver functional literacy strategy by incorporating family planning and TB modules into the Functional Literacy Facilitators' Guide and Learners' Primer that was developed by DOH, the Department of Education (DepEd), and UNICEF. The Project has trained trainers from all participating CHDs, and provincial and city health offices with the participation of DepEd alternative learning system supervisors of some provinces and General Santos City. The trainers of Negros Oriental, Eastern Samar, and South Cotabato have trained selected barangay health

workers as functional literacy facilitators. The mayor of San Jose, Negros Oriental has launched the functional literacy strategy in his municipality and classes are ongoing. Meanwhile, literacy mapping is being conducted to identify illiterate caregivers in the other two provinces. Family planning and TB were also integrated into the integrated MCH counseling cards which are tools for midwives and community volunteers in promoting key practices for MCH, FP, and TB.

LEAD undertook several training activities for LGU health workers and volunteers to improve their capacity to provide better health services, especially to hard-to-reach vulnerable groups. Training had revolved around community outreach peer education, risk reduction, counseling, and STI syndromic management.

Behavior change communication (BCC) interventions for most-at-risk groups (MARGs) were provided in various forms: brief contact/education, risk reduction counseling, and condom and IEC material distribution. Group sessions with female sex workers, males who have sex with males (MSMs), male customers, and injecting drug users (IDUs) also served to reinforce prevention messages among the MARGS, establish peer support, and decrease the stigma surrounding discussions around sensitive related issues. Referral systems for STI cases were also set up with barangay health clinics and social hygiene clinics.

Injecting drug users and MSM intervention model development activities were initiated during the year. Consultations were done with LGU and NGO partners in selected sites to develop the design of the intervention models. Preparatory work is ongoing to engage HIV/AIDS SIOs to pilot-test and implement the intervention models. LGU and program partners from the sentinel sites General Santos and Zamboanga agreed to adopt the Indigenous Leader Outreach Model (ILOM) to access and provide prevention intervention among injecting drug users. The MSM Intervention Model, meanwhile, will be pilot-tested in the cities of Quezon, Pasay and Baguio.

At the national level, together with the National AIDS STD Prevention and Control Program, the Project initiated the review and updating of the existing comprehensive STI case management module, and the development of appropriate teaching tools for use during the training of trainers. This is a coordinative effort with the National AIDS/STD Prevention and Control Program and is aimed at building LGUs' STI service provision capacity through trained CHD and provincial STI program coordinators who will be actively involved during the roll-out of the STI case management training at the LGU level.

Insights gained:

1. The early part of the second year was devoted to addressing the challenges presented by the existence of numerous and sometimes poorly coordinated TA activities. Technical specialists focused on developing their respective tools and products, and conducting their own technical assistance activities often without considering the

other technical areas. This was further aggravated by the practice of identifying and committing quarterly deliverables *by technical area*. This led the technical specialists to focus only on meeting their respective deliverables, making very little effort at integrating their TA activities and products with those of other technical areas.

To address this, LEAD developed the cohort approach in managing technical assistance provision to LGUs. The approach allowed the Project to identify the type and timing of TA for a particular batch of LGUs based on the estimated amount of resources (especially time) required to achieve specific performance targets. Focusing on specific targets at particular time periods has enabled LEAD to better prioritize project activities and efficiently program its resources. Technical assistance, whether by SIOs, in-house staff, or other collaborating partners, is organized to converge around specific performance targets.

2. LEAD aims to strengthen the governance and service capacities of LGUs for sustained provision of quality health services. Therefore, it is incumbent upon the Project to ensure that governance and technical components reinforce each other. Technical assistance in governance has to be closely linked with and anchored on the four core program areas (i.e., FP, TB-DOTS, MCH, and HIV/AIDS) so that all efforts to improve governance ultimately redound to better quality health service provision. LEAD's work with the leagues, the Health Leadership Management Program (HELM), local advocacy initiatives, and the Public Service Excellence Program (PSEP) should all revolve around securing support to sustained provision of quality health services in individual LGUs.

3. LEAD has had difficulty integrating HIV/AIDS activities with other LGU-based activities in the sentinel sites. The HIV/AIDS component has a set of SIOs different from the provincial SIOs engaged to work on the other project components. And although the direct recipients of HIV/AIDS interventions are the same LGUs that receive other TA from the Project, the eventual target beneficiaries are different from those of the other programs. Given these limitations, LEAD needs to find and utilize points of integration between the HIV/AIDS technical assistance interventions and those of the rest of the Project, primarily because these are directly targeted at the same audience group, the LGUs.

4. At the close of the second year, LEAD had developed several technical products – tools, processes, strategies – that have been used to help LGUs meet their performance targets. While efforts have been taken to slowly shift the responsibility of providing technical assistance to LGUs using these technical products, the Project needs to be more aggressive in doing this. There are partners at the local level that could take over the provision of technical assistance – CHDs, PHOs, CHOs, ILHZs, LMP members, as well as individual LGUs. The Project will have to devise a comprehensive scheme for preparing these partners to assume this responsibility, and eventually turn it over to them.

Goal #3. Establish a system for large-scale TA provision to LGUs

LEAD provides technical support to LGUs through several mechanisms. Early in the life of the Project, LEAD technical specialists were themselves often directly providing that assistance. This was because there was only a small number of LGUs then, and the technologies developed by the Project were still in the formative stage. As the number of enroled LGUs increased and project interventions became more developed, the responsibility of providing technical support to LGUs was expanded to include NGOs (called service implementation organizations or SIOs) which were contracted for this purpose, and entities such as the regional offices of DOH, POPCOM, and PhilHealth.

In Year 2, LEAD took deliberate steps to institutionalize the capacity for supporting LGUs by training trainers within CHDs and POPCOM, and the staff of selected SIOs. In Year 3, greater emphasis will be placed on shifting further the responsibility of and capacity for supporting LGUs to the appropriate local agencies (CHDs, PHOs, POPCOM, PhilHealth) for health services, and to LMP, DILG, local NGOs and others for governance. The objective is for LEAD to "work itself out of a job" as it ensures that existing institutions with mandates to support LGUs take in the new technologies and approaches introduced by LEAD.

In the second year, the Project issued 21 sub-contracts to 15 provincial SIOs to service the technical assistance requirements of a total of 347 LGUs. Six additional contracts were awarded for HIV/AIDS work in seven sites. LEAD field coordinators and their SIO colleagues actively sought out involvement in planning and implementing LGU support activities with their government agency partners. In some regions this took the form of technical working groups at the CHDs. In others, it involved consultations with the DOH regional directors. The emphasis in Year 2, however, was on enroling the contractually driven target of LGUs and pushing them as fast as possible to accomplish the 11 LGU performance targets to maximize achievements during the first three years of the Project.

Insights gained:

1. In August 2005, the Project undertook an internal assessment of how service implementation organizations were contributing to achieving the Project's objectives. The assessment results demonstrated that many of the SIOs are not functioning as originally envisioned.

   The original hypothesis was that NGOs already well established in a particular geographic region would be able to enhance project implementation because of their existing connections with local government officials and their ability to mobilize technical experts from within their own organizations, from government agencies, and by hiring externally. The evaluation however, showed that many SIOs were tapped to help organize workshops and training events, manage project resources for such activities, and to some extent monitor field activities. The contracting mechanism, i.e., indefinite quantity contract (IQC) with fixed-price task orders (TOs) used to engage SIOs served to reinforce a short-term, task-oriented approach rather

than a longer-term plan jointly developed between the SIOs and LEAD. Despite the fragmented and mechanistic roles assigned them, however, a few SIOs with many years of local experience did manage to function as full development partners as originally envisioned albeit with difficulty.

As a result of this assessment, and because USAID approved a geographic code waiver in June 2005 to go beyond the IQC/TO funding ceiling for local organizations, the project leadership decided to make the following changes: 1) the SIO contract mechanism will be changed from IQC/TO to cost-reimbursement contracts that will provide flexibility in carrying out activities without sacrificing the effectiveness of the PBC's purpose and the efficiency of doing things. This will allow the satisfactory achievement of deliverables for any activities approved in the work plan developed and agreed upon with the LGUs and pay the corresponding actual expenditures within the approved budget; 2) contracts were negotiated only with those SIOs that appear to offer value-added to the work in each province and other LGUs, and 3) project staff committed to share LEAD approaches and technologies with SIO colleagues as well as provide to experienced SIOs more latitude to use their own tested approaches to achieve project targets.

2. LEAD's self-assessment and the Year 3 planning workshop conducted on September 19-20, 2005 surfaced a major lesson: that a more customized approach to LGU technical support was needed. Project staff recognized that the 11 LGU targets are conceptually consistent with the general principles of the Health Sector Reform Agenda (HSRA) as they deal with building local health **policies** and health **financing,** and improving **services**. LGUs move forward at different pace and deliver accomplishments in different parts of the health system. The ultimate task is to ensure that all three elements of HSRA are developed and institutionalized in each LGU or cluster of LGUs as appropriate.

   It is critical for LEAD to understand and use every opportunity to introduce, in terms that are meaningful to local chief executives, the rationale and urgency for investments in family planning and other health services. Based on similar suggestions of the external assessment, LEAD will, in Year 3, group LGUs based on progress towards accomplishing performance targets, and place greater emphasis on monitoring reduction in unmet need for family planning services (IR11). This will provide better empirical evidence that the technologies supported by LEAD will enable LGUs to achieve national goals in population and health.

Goal # 4. Implement the LEAD strategy for ARMM

Staffing. Early on in Year 2, LEAD engaged the people necessary to intensify its work in the Autonomous Region in Muslim Mindanao. In the second quarter, a team leader for Mindanao was engaged to provide oversight and support to the implementation of the ARMM Strategy for Health Improvement. At the same time, the Technical Working Group for ARMM was organized, with representatives of the different technical units as members. An ARMM specialist was engaged in the third quarter.

Staffing for ARMM was vigorously pursued in the fourth quarter of Year 2. And as decided by project management, an additional field coordinator will be hired and a separate field office for ARMM will be set up.

The ARMM Strategy for Health Improvement. In the first quarter of Year 2, ASHI was introduced to major stakeholders – national DOH, DOH-ARMM, PHIC – who adopted it as their own. In February 2005, the Project supported the formal launching of ASHI by the ARMM regional government during the ARMM Health Summit in Manila. The summit was participated in by various stakeholders from the national, regional, local, and ARMM government agencies as well as representatives from both Houses of Congress, foreign embassies, international donor agencies, NGOs, private sector agencies, and LEAD for Health partners. Subsequent activities included the development of the ARMM Regional Plan on the Implementation of ASHI and National Assistance Packages for ARMM Workshop. The ARMM Regional Economic and Development Planning Board chaired by the regional governor concretized in June 2005 the official adoption of ASHI through Board Resolution No. 09 series 2005.

With the completion of the USAID ARMM Strategy for Health Improvement, the Project brainstormed in November 2004 on how to enhance project implementation in ARMM within the ASHI framework. In January 2005, the Project submitted to USAID its strategy paper on project interventions and approaches in ARMM. Several consultations on the crafting of the ARMM Implementation Plan were held with partners and USAID between April and May 2005. The ARMM Implementation Plan was finalized and submitted to USAID in June 2005.

In December 2004, the Project officially engaged Sulu and Basilan, the two remaining provinces in ARMM. Thus, by the second quarter, the entire ARMM – all five provinces and Marawi City – were officially engaged in the Project. At present, all IPHOs and Marawi City Health Office have finalized and approved the plans on how to improve governance and health service capacities in their areas.

The Project continued to engage on-board SIOs to assist the provinces of Maguindanao (Save the Children Federation – SCF) and Lanao del Sur (Helen Keller International – HKI) and for the Marawi City (HKI). Two additional SIOs – SCF for Sulu and Christian Children's Fund (CCF) for Basilan were also brought on board. However, to date there is still no engaged SIO for the province of Tawi-Tawi due to the withdrawal of the ACDI-VOCA and the subsequent lack of bidders.

- **National DOH Output Package.** As a result of the National Assistance Package Workshop for ARMM conducted in April 2005, the National DOH is formalizing its commitment to support ASHI objectives through an Administrative Order, "Implementation Guidelines on the DOH Technical Assistance Package in Support of ASHI." With the appointment of a new Secretary of Health, the National DOH is currently revising the draft AO to align it with the DOH Fourmula One framework.

Even while the AO is still being finalized, however, key national DOH bureaus and offices have been providing assistance to the implementation of ASHI. These include the Procurement and Logistics Service (PLS) on contraceptive distribution and management, Bureau of Local Health Development (BLHD) on Sentrong Sigla, National Epidemiology Center on FHSIS and ICD 10, Bureau of International Health Cooperation (BIHC) on coordination with WHO on ICD 10, and the Health Policy Development and Planning Bureau on the AO formulation. The contribution of National DOH to the facilitation of the ASHI processes through the Mindanao Health Development Office could not be overemphasized.

- **DOH-ARMM Output Package.** After the ARMM regional planning workshop on ASHI, DOH-ARMM organized its ASHI TWG to oversee the region-wide implementation of the strategy. As a result, the DOH-ARMM staff are starting to become more visible in the field, providing technical assistance and oversight. In fact, licenses of several provincial and district hospitals have been currently renewed by DOH-ARMM officials after two to three years of non-renewal. At present, a regional capacity development assessment is on-going to review the ability of DOH-ARMM to carry out its roles and functions.

  The ARMM health summit pointed out that multiple donor inputs to ARMM need to be coordinated and rationalized. DOH-ARMM thus outlined its need to come up with an investment framework that they have initially branded ARMM Cooperation in Health System (ArCHeS). A LEAD consultant is currently assisting with its development.

  Assistance was provided to address the phase-down of donated contraceptives. In June 2005, a regional consultative forum was conducted on AO 158, "Guidelines on the Management of Donated Commodities under the Contraceptive Self-reliance (CSR) Strategy." In response, DOH-ARMM, through its Secretary, defined the framework for the region – the ARMM CSR Plan. He has also committed to allot between one to two million Philippine pesos from DOH-ARMM's Special Program Fund to procure contraceptives for next year. In September 2005, DOH-ARMM conducted its commodity forecasting together with the IPHOs/CHO, LEAD, and partner SIOs.

  In Year 2 various capability building activities for health care providers and BHWs were conducted in the region in the areas of family planning, maternal and child health, Vitamin A supplementation, and TB health systems improvement. Groundwork was laid for expanding access to all modern FP methods through the facility assessments and trainings done on IUD and BTL.

  CBMIS was piloted in the municipality of Wao, Lanao del Sur. Results are encouraging with the identification of 584 couples with unmet need on FP and initial results showing 46 clients were provided with FP services (45 BTL and 1 IUD).

- **PHIC Output Package.** In the second quarter of Year 2, a consultant's report on PHIC was submitted to LEAD. During this time the first RHU provided TA by the Project (i.e., Wao, Lanao del Sur) was PHIC-accredited for its out-patient benefit package. Borne out of the inputs of the consultant's report and the experience in Wao, steps were taken in the third quarter to fasttrack PHIC accreditation of health facilities in ARMM. Thus, the ARMM Accreditation Composite Team (ACT) was organized composed of representatives from DOH-ARMM, ARMM IPHOs/CHO, National PHIC, PHIC regional offices, LEAD, and partner SIOs. In the fourth quarter, ARMM ACT went on a round of pre-assessment visits to all five provinces of ARMM and Marawi City covering a total of 79 health facilities. Of these, 27 were accredited for OPB package and seven for the maternity care package (MCP). The rest are working on the completion of PHIC requirements.

  In support to the promotion of social health insurance in the region, both the out-going and incoming ARMM regional governors have expressed their commitment to expand PHIC enrolment of indigents towards attaining universal coverage.

- **Advocacy Output Package.** Through various forums and individual consultations, political leaders were provided advocacy TA. This assistance has resulted in the commitment of Maguindanao mayors to enrol 28,000 indigents in the National Health Insurance Program (3,000 of these have already been enroled); and 10 local health boards made functional in the provinces of Sulu, Basilan, Tawi Tawi, and Lanao del Sur. In addition, health ordinances were formulated in Basilan and the user fee for health services scheme were initiated for services in the municipality of Wao in Lanao del Sur.

  In Marawi City, the mayor, a former official of the Moro National Liberation Front, used to be skeptical of family planning. But LEAD's presentation on "Population and Health Management as Instruments for Peace and Development" convinced him enough to support the city's FP program. Lately, he announced that PHIC capitation funds shall be used to procure FP commodities for the city. He also instructed his staff to enrol 6,000 more indigents in NHIP.

  LEAD provided advocacy TA to Muslim religious leaders (MRLs). In Basilan, this was carried out using a novel approach – the engagement of women MRLs or *alimas* to encourage the active participation of women in FP??. Also through advocacy approaches, service provision was facilitated in several conflict areas. This is evidenced by access to FP services in evacuation centers during the February 2005 outbreak of hostilities in Sulu, and the universal Vitamin A supplementation activities in the region during the regular *Garantisadong Pambata* campaigns.

- **Community-based Output Package.** A participatory health appraisal was developed to identify unmet needs for service provision in hard-to-reach

communities. The Project will enggae a consultant to assist ARMM in enhancing and expanding existing community-based health models.

Insights gained:

1. Organizationally, ARMM was originally part of the Mindanao field office staffed by two field coordinators covering the five provinces and two cities. The lack of enough manpower and management time devoted to ARMM inordinately slowed down the work in the region. Subsequently an ARMM technical specialist was hired in April 2005. More recently a decision was made to separate ARMM and non-ARMM Mindanao into two geographic regions with a full time team leader devoted to ARMM. In addition, a series of short-term consultants were hired to work on the various elements of the implementation plan. These moves have greatly accelerated the pace of activities in ARMM. Weekly updates on ARMM activities are provided by the ARMM team leader to the LEAD senior staff on a weekly basis.

2. Initially, LEAD attempted to use the same approaches it did for non-ARMM LGUs without sufficient understanding of the differences. The development of ASHI along with the discussion that led to the development of the LEAD Implementation Plan helped shift gears. Project indicators specific for and appropriate to the health conditions in ARMM were developed.

3. LEAD staff learned that work in ARMM was greatly affected by the lack of infra-structure and the fragile health care system itself. The assumptions made for other areas often did not apply to ARMM because the starting point was different. For example, the Community Output Package in the LEAD ARMM strategy identified an approach directed toward hard-to-reach areas with practically no access to health care (defined as Level 3 communities in the Implementation Plan). Interventions at this level must be crafted on the assumption that these areas have no health infrastructure or staff but have a pool of community-based volunteer workers (i.e, BHWs, traditional birth attendants, NGOs, or community/people's organizations) who can serve as program implementation partners. Too, many of the approaches used must be participatory to be accepted.

4. LEAD has also learned that positive results can be achieved despite the myriad challenges in ARMM. Organizing and mobilizing the ARMM Accreditation Composite Team has ushered in a breakthrough: it fasttracked hospital licensing and PHIC accreditation activities. ACT is composed of DOH-ARMM staff, PhilHealth national and regional staff, IPHO technical staff, and LEAD project staff who have banded together to assist the five ARMM provinces and Marawi City during pre-assessment. ACT is an example of a team strategy that has catered favorably to the distinct situation in ARMM. LEAD hired a consultant to work with PHIC and DOH to undertake an accelerated accreditation program that has yielded excellent results to date. The combination of political level attention to the issue of enroling beneficiaries and determination to stimulate good results in a neglected region has paid off. During a 2½ month period, 79 RHUs were pre-assessed of which 27 completed accreditation

for OPB and seven for MCP. This is a significant accomplishment for a short period of time.

5. Donors working to help ARMM do so in an uncoordinated fashion. LEAD's strategy to address this weakness is to support DOH-ARMM as the focal point for such coordination. Currently, a LEAD consultant is developing an operational framework for investments as a tool for analyzing resources and activities in ARMM, and providing planners with a mechanism/tool for organizing donor inputs. A meeting is planned for December 2005 to discuss this framework??, and support DOH-ARMM's effort to guide donor investments. By focusing on DOH-ARMM, LEAD believes that the capacity to continue working strategically with donors will be a lasting contribution to the region.

6. Given the "uniqueness" of the non-devolved set-up in ARMM, LEAD builds on team approaches and close coordination among the different stakeholders at the national and regional levels, and the provincial and city program implementers. The designation of focal persons at DOH-ARMM as members of the ASHI Technical Working Group was crucial in addressing concerns for the different ASHI output packages. The TWG was helpful and facilitative in implementing LEAD activities in the region. The LEAD Project offered opportunities for improving coordination and strengthening partnerships between the regional and provincial stakeholders as well as those from health care providers and their local government executives.

Goal #5. Conclude the formulation of, and pursue the 10-point Policy Agenda

The policy agenda seeks to create an enabling environment conducive to the delivery of enhanced and effective health services. It also provides inputs to various advocacy activities at the LGU level to support these health services. The 10-point Policy Agenda represents the policy development initiatives of DOH, PhilHealth, POPCOM, and LGUs in collaboration with other USAID cooperating agencies. These initiatives aim to contribute to policies that would make the health sector more effective, efficient, and equitable in producing health outcomes, especially in family planning, TB-DOTS, Vitamin A supplementation, and HIV/AIDS prevention and surveillance.

The policy agenda was crafted with the Project taking the lead in coordinating various consultations, discussions, and writeshops with other CAs and national partners. A common framework of the health sector guided the group in identifying areas for policy decision and policy development. Policy issues identified by DOH, PhilHealth, POPCOM, and LGUs were prioritized to arrive at the 10-point Policy Agenda. A common workplan, based on a single policy development process has been developed and is being implemented to pursue specific elements of the policy agenda. A Policy Forum Steering Committee has been formed to provide guidance to the policy work of specific CAs and partner-institutions. LEAD provides overall secretariat and logistics support.

Apart from its role as secretariat, LEAD is also taking primary responsibility for pursuing the following policy areas:

- Policies related to DOH certification and PhilHealth accreditation
- Expanding PhilHealth benefit packages for FP, TB-DOTS, and Vitamin A supplementation
- Decentralizing PhilHealth operations to improve efficiency
- Strengthening national policies in support of CSR+
- Financing policies for the national HIV/AIDS surveillance system
- Strengthening local policies for financing and delivery of key services through CSR+ planning and ELAHs

Insights gained:

1. Pursuing a national-level policy agenda cannot be the responsibility of one project, or a single USAID cooperating agency alone. The achievements that have been chalked up in moving the agenda forward are a result of LEAD's close collaboration with other CAs and national agencies. Collaborative work has utilized the strengths of specific CAs in particular policy areas, focused their energy on policy areas that they are most confident in making an impact on, and allowed maximum use of pooled resources to be consistently directed at achieving the objectives of the policy agenda.

2. The active engagement of national partner-agencies in the endeavor, DOH in particular, has been critical. Department and administrative orders from the health department have been useful in organizing and focusing the work of several collaborating agencies from the public and private sectors around the items in the policy agenda.

3. Broad-based consultation with various stakeholders ensures wider and faster dissemination and adoption of policies and action agenda. Consultation is also useful in building alliances for action and advocacy in other related fields of concern.

Goal #6. Establish the implementation feasibility of the planned performance-based grants program

The Performance-based Grants (PBG) program is an innovative mechanism that encourages and rewards LGUs' good performance in health service delivery. Using the PBG mechanism, the LEAD for Health Project will disburse funds to LGUs subject to the satisfactory achievement of specified performance targets. The payment is contingent on technically acceptable and verifiable LGU achievements or deliverables. Thus, LGUs have an incentive to achieve specified outputs.

MSH received from USAID approval of the PBG advanced implementation (PBG AI) program in March 2005. The Project has since proposed to conduct an advanced implementation of the program to test and evaluate the effectiveness of PBG in encouraging rapid achievement of LGU performance targets, and reinforcing

sustainability of results. Upon approval of the program, the Project proceeded with the development of advanced implementation guidelines with the engagement of short-term technical assistance. An initial set of guidelines was approved by USAID in August 2005, but this is going to be further finalized before the end of October 2005 to reflect additional provisions agreed upon with USAID. The guidelines will guide the current and future PBGs. It will be updated from time to time to incorporate changes and enhancements as the need arises.

PBG AI allows 28 grants to be awarded to two provinces and 23 municipalities/ component cities in non-ARMM areas, and three provinces in ARMM. Following USAID's acceptance of the final draft of the PBG AI guidelines in August 2005, LEAD contacted participating LGUs regarding the program. Orientation meetings were conducted for their LCEs and other LGU officials, and communication materials were disseminated to provide details of the program's salient features. Furthermore, negotiations with LGUs on the performance benchmarks have been completed, mandatory benchmarks have been outlined, and the menu of optional benchmarks was offered for participating LGUs to choose from.

The Project recently changed all optional benchmarks into mandatory. This was in response to an observation made by the mid-term assessment that benchmarks on results were treated optional.

MSH expects to complete the grant signing with the LGUs in non-ARMM areas no later than November 2005. PBG in ARMM, however, is anticipated to begin with its preparatory activities in Year 3 upon receipt of USAID's approval of the participation of Tawi-Tawi, Sulu, and Maguindanao provinces in the PBG program. In late September 2005, ARMM benchmarks developed in 2004 were revised so that benchmarks that ensure actual delivery of health services in participating provinces are included. The revised benchmarks are expected to be finally approved by USAID in October 2005.

Insights gained:

1. There have been many debates on the merits of PBG itself, and on how it should be constituted. These, however, will remain unresolved until the Project gains experience in and learns from implementing the program. The proposed advanced implementation is intended to serve this purpose.

2. During the selection period, not all provinces welcomed the PBG mechanism. This was evident in the case of Pangasinan, which believes that MSH's introduction of cash grants might only foster further dependence on outside help, and work against the province's efforts to achieve sustainability. Individual LGUs in the province seem to be capable of achieving their performance targets without additional cash grants. The fact that not all LGUs need or want such cash grants is in itself an important lesson even before implementation begins.

3. To avoid confusion, decisions that have not been finalized (e.g., the full amount of the grant will be awarded because it is a reward for performance) must not be relayed to the LGUs to avoid raising expectations and frustrations.

C. Challenges for Year 2

The Project will take on a number of major challenges in Year 3 to achieve the end-of-project performance targets. These include:

1. Focusing on Key Results

LEAD realized from the review of Year 2 and planning for Year 3 as well as the recommendations from the external assessment that it is important to tailor technical assistance that responds to where the LGUs are in term of achieving the Project's performance targets. Some LGUs have moved ahead rapidly, while others were either enrolled later or are simply slower in making progress on those indicators chosen to measure progress towards achieving the Project's goals.

LEAD staff were also reminded that while all the goal areas are important, the family planning-related goals are of seminal importance given the original MSH proposal's and contract's emphasis on showing progress in CPR. The FP-related end-of-project targets are also the most challenging. While the technical products developed and employed by the Project should help achieve the goals in family planning, it is important for LEAD to show convincing evidence that these in fact have been effective in contributing to SO3 goals. The Project decided, therefore, to focus on FP unmet need reduction among more advanced LGUs that had a functioning CBMIS and had attained the set of policies and funding required to ensure sustained progress. The approach needs to be customized for LGUs in terms of what they already have in the three major areas of health reform (viz., policies, financing and services). This effort is described in detail in the Year 3 Work Plan.

The Project, therefore, has to devise a separate approach for helping fast performers achieve the performance targets they are ready to complete. This approach should be different from that used for LGUs that need more groundwork to yield the expected results. This implies that not only must the approach be different for each group; the outcomes they are expected to show after a specific period must also be different.

The fast performers should be ready to work on reducing FP unmet need. The effort should include bringing successful governance efforts (e.g., LMP strategy) together with increased attention to ensuring that couples with FP unmet need are targeted for services. At the same time, emphasis needs to be placed on PHIC accreditation, enrolment, and services to help establish sustained financing mechanisms to reinforce the effort to institutional budgetary allocations for FP commodities.

The rest of the LGUs will require a different approach that gives them more technical assistance and time in meeting their performance targets. Judging from the overall

performance of engaged LGUs in the past two years, especially the slower performers, it would not be realistic to expect them to meet all IRs by the end of the Project's third year. It is important, however, to specify a minimum set of performance targets that they should aim to deliver by Year 3. Completion and implementation of the CSR+ plan, including budgeting for as well as purchasing and distributing commodities should be among the highest priorities.

In summary, the challenge for Year 3 is to demonstrate that the high-performing LGUs who are achieving many of the other performance targets can demonstrate substantial achievements in reducing FP unmet need. At the same time, the other LGUs will receive project support to achieve as many of the IRs as possible. Concomitantly, there will be aggressive efforts to ensure that LEAD's investment are sustained over time by the LGUs and that the LGUs are provided the necessary support from government institutions mandated to do so.

2. Institutionalization

The LEAD for Health Project aims to strengthen LGU governance and capacity for quality FP, TB-DOTS, MCH, and HIV/AIDS service provision. Its mandate is to find cost-effective and sustainable ways of providing health technical and governance support to LGUs. In the past two years the Project has supported the development of systems and processes to enhance local capacity, improve access to people for technical support to governance and quality health service delivery, strengthen organizational structures such as local health boards and regional technical assistance teams, and create and promote an enabling environment for resource mobilization through appropriate policies and ordinances to support health budgets. Sustaining all these after the Project ends is a major challenge that LEAD is addressing. In the third year, LEAD must begin to implement steps to institutionalize and sustain these gains. Full institutionalization cannot be completed within the first three years of a seven-year project, but concrete steps must be planned and implemented during the Project's third year which will lead to a fully sustained LGU support system in later years.

The third year of LEAD should thus be devoted to consolidating the learning and accomplishments of the past two years and working towards full institutionalization of the developed systems, processes, and programs, which is anticipated to begin in the Project's fourth year. LEAD's Year 3 will address the two major challenges in successful institutionalization: 1) engaging the political, financial, and organizational support and commitment of the partners to continue the kind of support that LEAD has been providing the LGUs; and 2) strengthening the capacity of partners to provide technical and/or governance support to the systems, processes, and programs now in place at the LGU level.

3. LEAD within DOH's Fourmula One Framework

Fourmula One (F1) is DOH's framework for implementing health reforms aimed at improving the efficiency, effectiveness, and equity of the Philippines health system. It

was officially launched through Administrative Order No. 2005-0023 dated August 30, 2005. It organizes the critical reform initiatives into four implementation components:

- Financing (more, better, and sustained)
- Regulation (assured quality and affordability)
- Service delivery (ensured access and availability)
- Governance (improved performance)

The health reforms are to be carried out sector-wide, and will initially focus on 16 convergence provinces, with a roll-out into 15 additional sites planned in 2008. The various DOH offices have been rearranged into teams to respond to the implementation requirements of F1.

The LEAD for Health Project falls within the F1 framework, and its activities span across all four components of Fourmula One. Furthermore, LEAD is already working at the LGU level in nine of the 16 F1 provinces. It thus provides for an advanced implementation of health reform activities. Therefore, the recommendation of the external assessment to align LEAD with F1 makes logical sense. The alignment will produce the following added advantages:

1. While LEAD activities support Fourmula One, F1 itself becomes an effective strategy to attain LEAD objectives and ensure its sustainability.
2. F1 provides the framework that can assure the relevance and the proper direction of LEAD activities.
3. F1 provides the official forum where LEAD can report its accomplishments, and its contributions to the attainment of national health objectives.

In addition, the 10-point Policy Agenda, six of which are the direct responsibility of LEAD, are all within the F1 framework, and will proceed as planned.

Beginning the third year, LEAD will work actively with the new DOH F1 initiatives.

4. Organizational Changes

With the transition in leadership of the LEAD Project in March 2005, shifts in senior personnel were initiated in consultation with USAID. It was also recognized at that time that adjustments were needed in the organizational structure of the Project to reduce "stove-piping," improve efficiency, and strengthen the support to field offices. To complete the process begun earlier, a consultative meeting between Project staff and management was held in August 2005 to discuss problems with the current structure and make recommendations about the organizational alternatives. The new organizational chart represents the strong consensus that emerged from that meeting. It established a senior Field Operations Unit Director position that reports directly to the Chief of Party, integrated technical and governance support for field operations under the Deputy Chief of Party, consolidated administrative functions, provided for greater delegation of

authority to field units, and instituted other changes designed to provide better support to the field and client LGUs.

IV. Plans for the Ensuing Period

To address the Year 2 outstanding issues and move the Project closer to attaining its end-of-project deliverables, LEAD is setting the following goals to achieve in its Year 3 work plan:

1. Provide technical assistance to at least 530 life-of-project LGUs to enable them to achieve their performance targets:
    a. Focus TA to approximately 140 advanced LGUs in meeting the objective of at least 50% FP unmet need reduction
    b. Provide TA to 300 less-advanced LGUs in the attainment of their performance targets and the implementation of their CSR+ plans
    c. Assist 100 ARMM LGUs in the attainment of their performance targets
    d. Fasttrack PHIC accreditation in at least 100 eligible, pre-qualified LGUs

2. Accelerate the implementation of the LEAD strategy for ARMM
3. Complete the advanced implementation of the performance-based grant program
4. Implement the 10-point Policy Agenda within the Fourmula One framework
5. Consolidate the learning of the two-year LEAD experience and begin the process of institutionalizing and sustaining the gains that have been made
6. Perform focused reviews with partners on selected technical products of the Project

With these goals in mind, the revised work plan for Year 3 will fully describe the implementation of these goals during the third year of the Project.

Local Enhancement and Development (LEAD) for Health Project Staff List

Surname	Firstname	Department/Unit	Position
Alcala	Earl Enrico	Field Operations (Mindanao)	Field Coordinator
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Anduzon	Elizabeth	Peformance-based Contracts (PBC)	Contracts Assistant
Anung	Luz Divina	Field Operations (Mindanao)	Field Coordinator
Aranas	Consuelo	Family Planning and Health Systems Unit (FPHSU)	FPHSU Director
Asia	Melody	Policy Unit	Project Assistant
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Cacas	Melody	Finance and Admin (F/A)	Finance Staff
Calixto	Franco Joshua	Peformance-based Contacts (PBC)	Contracts Specialist
Capul	Rosendo	Chief of Party's Office	Senior Advisor to the Chief of Party
Castillo	Dolores	Chief of Party's Office	Deputy Chief of Party
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Surname	Firstname	Department/Unit	Position
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Surname	Firstname	Department/Unit	Position
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Maglaya	Cesar	Family Planning and Health Systems (FPHS)	FP Clinical Training Advisor
Manalo	Juanita	Family Planning and Health Systems Unit (FPHSU)	Project Assistant
Mantala	Mariquita	Family Planning and Health Systems Unit (FPHSU)	TB Dots Specialist
Manuel	Cecilia	Project Performance Monitoring Unit (PPMU)	LGU Program Performance Specialist
Marin	Ma. Celia	Finance and Admin (F/A)	Finance and Administrative Manager
Masulit	Saniata	Project Performance Monitoring Unit (PPMU)	Resource and Documentation Specialist
Mesina	Mae	Local Government Unit (LGU)	Project Assistant
Navarro	Dorothea	Field Operations (Luzon)	Field Coordinator/Team Leader Luzon
Nicanor	Indira	Finance and Admin (F/A)	Administrative Assistant
Obelidhon	Rae Christine	Finance and Admin (F/A)	Administrative Assistant for Mindanao
Ojascastro	Roziel	Finance and Admin (F/A)	Administrative Assistant/ Receptionist
Pangato	Ibrahim Jr.	Field Operations (Mindanao)	Field Coordinator ARMM
Pilapil	Jocelyn	Human Resources Department (HRD)	HRD Manager
Piñero	Mary Angeles	Field Operations (Visayas)	Team Leader Visayas

Surname	Firstname	Department/Unit	Position
Quiambao	Miraflor	Field Operations	Project Assistant
Quiazon	Jesus Verne	Policy	OIC Policy Unit
Rodriguez	Jose	Chief of Party's Office	Senior Advisor to the Chief of Party
Romasanta	Leonila	Field Operations Mindanao	Field Coordinator Non -ARMM
Salipot	Alipio Jr.	Project Performance Monitoring Unit (PPMU)	IT Specialist
Serafica	Rosalynn Madeleince	Family Planning and Health Systems Unit (FPHSU)	Behavior Change Communication (BCC) Specialist
Singh	Joseph Michael	Field Operations Mindanao	Team Leader ARMM
Sucgang	Agnes	Field Operations Visayas	Field Coordinator
Tayko	Jennifer	Finance and Admin (F/A)	Administrative Assistant for Visayas
Tomas	Sarah	Project Performance Monitoring Unit (PPMU)	Database Administrator
Tuazon	Catherine	Finance and Admin (F/A)	Accounting Assistant
Ubalde	Lorenzo	Field Operations Luzon	Field Coordinator
Viola	Grace	Field Operations Luzon	Field Coordinator
Yao	Ma. Suzetta	Finance and Admin (F/A)	Office Manager
Zambales	Manuela Asuncion	Finance and Admin (F/A)	Accounting Assistant